SJR 22 Joint Subcommittee on Health Care and Health Insurance

57th Montana Legislature

MINUTES

Please Note: These are summary minutes. Testimony and discussion are paraphrased and condensed. Committee tapes are on file in the offices of the Legislative Services Division. **Exhibits for this meeting are available upon request. Legislative Council policy requires a charge of 15 cents a page for copies of documents.**

Fifth Meeting of Interim
Room 137, State Capitol
April 4, 2002

SUBCOMMITTEE MEMBERS PRESENT

Rep. Joe McKenney, Chair
Sen. Jon Ellingson, Vice Chair
Sen. Dorothy Berry
Sen. Royal Johnson
Sen. Jerry O'Neil
Sen. Linda Nelson
Sen. Glenn Roush
Rep. Kathleen Galvin-Halcro
Rep. Bob Lawson
Rep. Gary Matthews
Rep. Bill Price
Rep. Trudi Schmidt
Rep. Bill Thomas

SUBCOMMITTEE MEMBERS ABSENT

Rep. Michelle Lee

STAFF PRESENT

Gordy Higgins, Research Analyst
Bart Campbell, Staff Attorney
(Transcribed by Lois O'Connor, Secretary)

VISITORS LIST AND AGENDA

Visitors' list (ATTACHMENT #1)
Agenda (ATTACHMENT #2)

COMMITTEE ACTION

- Approved the minutes from the February 14, 2002, meeting as amended
- Approved that the Subcommittee write a letter to DPHHS encouraging it to work with the National Association of Chain Drug Stores to identify alternative cost containment measures related to reimbursement rates to pharmacy providers
- Approved that the Subcommittee support the continued study of the creation of a standing interim committee to review and monitor health care policy rather than the reestablishment of a Health Care Advisory Council

CALL TO ORDER AND ROLL CALL

The meeting was called to order by Rep. McKenney, Chair, at 9:00 a.m. Attendance was noted; Rep. Lee was absent. (ATTACHMENT #3)

Sen. O'Neil **moved** that the minutes from the February 14, 2002, meeting be approved as amended with the following change:

- Page 3--Paragraph 1 following final bullet:
  - ~~Some Subcommittee members~~ Sen. Ellingson expressed. . . .

Sen. O'Neil's motion passed unanimously.

PLEASE NOTE: This change has been made to the original minutes which are on file in the offices of the Legislative Services Division.

REPORT FROM TAX CREDIT WORKING GROUP

Sen. Ellingson stated that comments and contributions were received from a wide range of interested parties, including the Governor's Office. The Working Group viewed its task as one in which it would assume that there was the possibility of a funding source for a tax credit. Making that assumption and recognizing that any tax credit was going to cost money, it focused on what type of a tax credit it should be and how it should look in the event that a funding source was found.

Sen. Ellingson provided a summary of the Tax Credit Working Group Activities. (EXHIBIT #1) He stated that at this point, the Working Group needed some response from the Legislative Fiscal Division as to what the options might cost. Only after that feedback was received could it decide what options to recommend to the Subcommittee.

Rep Lawson added that the Working Group reviewed past legislation that provided employers a tax credit for providing disability insurance to employees. The tax credit did not provide a lot of dollars and was, therefore, used very little. The tax credit was also tied to a basic insurance group. The Working Group also reviewed legislation from the 2001 Session. In addition, it tried to deal with the 18.5% uninsured population while still not forgetting those people who currently have insurance but who are struggling to keep it. The biggest unknown that has yet to be built

into the variables and assumptions is appropriate funding. Instead of crossing that bridge first, the Working Group chose to develop a model that could work and attach a price tag later.

Rep. Price said that the best part of the meetings has been the good participation from the non-legislative public sector and the private sector. He did not believe that the Working Group could reinvent the wheel, but it is going to try something and it is a good start.

Gordon Higgins, Research Analyst, Legislative Services Division, stated the following:

- Since the Working Group's conference call, there was some interest in the question of how a tax credit proposal affects deductibility.
- Currently, 100% of the premiums paid can be deducted either as an individual filer or as a business.
- According to the Department of Revenue's Biennial Report, the deductibility of health insurance premiums for individual income tax filers is established as a tax expenditure.
- The Department estimates that for the biennium that estimate is approximately $21 million.
- In effect what the Working Group was struggling with was should people be able to take the tax credit on top of the tax expenditure or some combination or is there a way to apportion the value of the tax credit or the deduction so people are not getting the full value of each. This is a policy question that the Working Group and the Subcommittee needs to address.
- For those who file corporate tax, the Department does not consider the deductibility as an expenditure. It is the cost of doing business that it is not easily identifiable, and he was unsure whether the Department could come up with an accurate number.
- He assumed that the amount was a fairly high dollar figure, and it may shape how the Subcommittee begins to work with the question of providing the tax credit at a level and dollar amount and how it affects deductibility.
- He was also working with David Kendall (Progressive Policy Institute) on tax credits and how they can be implemented at the federal level. Mr. Kendall is sure that there are some reasonable methods of determining take-up rates.
- The higher the credit value and the more simple it is, the assumption can be made that there will be a greater take-up rate.
- Eventually the Subcommittee will have to come up with a number that it feels that will effect the bottom line. If the Subcommittee estimates that only 20% are going to take it up and it 50% take it up, the fiscal note is going to be a shock. This will be a critical number.
- Two other Working Group topics that were left unresolved are first, the issue of whether or not a benefit package should be tied to the use of the tax credit.
- The current tax credit opportunity in Montana is tied to a basic health plan. The question is can more value be gotten out of a tax credit by creating a benefit package that establishes a deductible, that is reasonable, and that establishes basic benefits as an incentive to get people to purchase insurance who either cannot afford it or do not want to purchase it.
- The second issue is purchasing pools and whether small businesses should be required to use or join a purchasing pool in order to take advantage of the credit.
- By pooling the purchasing power of small groups, it may increase the value.
- Purchasing pool concepts have the same mechanical issues associated with it, such as mandatory participation, mandatory lengths of stay within the pool, and how insurers rate risk within the pool.

- Purchasing pool options could be attached to the tax credit recommendation.
- According to most research, the design of a tax credit needs to be refundable and advanceable in order to get assistance to those people who are in need of the tax credit.
- In talking with the Department, this is going to be a complex administrative process, and there needs to be solid consensus on the design features within the Working Group before it moves forward with it.
- Initial figures on the cost projections will be available prior to the June meeting if possible.

Sen. O'Neil said that when he expressed his agreement that there should be a tax credit for health care, he was not thinking about increased funding if it meant more money out of his constituents' pockets. He felt that if the Subcommittee was contemplating providing an advanceable and refundable tax credit for people who are at poverty level or 80% of the poverty level, that it also consider the possibility of them filing a tax form for the credit to be used for CHIP or other insurance. He felt it unfair that a person who pays taxes has to fill out a tax form in order to get the tax credit while others receive the tax credit without hassle and without paying any taxes at all. He said that everyone should have to fill out the form so that everyone is treated the same.

Rep. Lawson asked if the $21 million would be a direct hit on the general fund revenue stream or would it be tax deductible and, therefore, be a percentage. Mr. Higgins said that the $21 million is estimated by the Department and is recognized as an expenditure.

Rep. McKenney said that it was his desire, along with Sen. Ellingson's, to put forth a proposal for a tax credit with the goal of reducing the number of uninsured Montanans. The Subcommittee could debate the issue of funding for the rest of the interim, but the Legislature is going to ignore that debate and have its own debate. He suggested that when the Subcommittee discusses funding, that it recognize that the tax credit will cost money and that it is a hit to the general fund. Other funding options, such as the coal tax trust fund, Commissioner Morrison's recommendations, and the tobacco settlement money, should also be included in the funding options list. The Subcommittee is not necessarily promoting one or any of those options.

Sen. Johnson asked why a tax credit was being considered rather than a deduction and who currently receives a tax credit for paying health insurance premiums in Montana. Mr. Higgins said that under the existing tax credit which is $35 an employee for small businesses, the revenue report lists it as an expenditure. However, it does not list the total amount because it is less than $25,000. He guessed that very few, if anyone, use the existing tax credit. In order for a tax credit to be a useful way to move numbers out from the uninsured column, the tax credit has to be a substantial portion, at least 50%, of the average annual premium which is much more than it is currently.

Sen. Ellingson added that currently, there is a deductibility feature in statute. On a statewide level, individuals who pay for medical insurance premiums can deduct them at a projected cost to the state of approximately $21 million. Given that, there is still an 18.5% uninsured population in Montana. The idea of adding a tax credit along with the deductibility is to induce more small businesses to provide insurance for their employees, to induce more individuals who are not currently buying insurance to buy insurance, and make it affordable for them to do that.

Sen Johnson said that uninsured people are uninsured because (1) they can afford insurance but do not want to be insured or (2) they cannot afford insurance at all. People who cannot afford insurance do not need a tax deductibility or a tax credit because they truly cannot afford the insurance. He was unsure why a tax credit should be given to that certain group of people rather than give it to everyone. He asked if Sen. Ellingson's tax credit idea included any person who pays an insurance premium. Sen. Ellingson said that the Working Group is reviewing those individuals who cannot afford to pay for insurance to figure out a ways to make insurance more affordable for them. Sen. Johnson asked if individuals or small businesses could not afford insurance and choose not to buy it under current conditions, would they be able to afford insurance even with a tax credit. Sen. Ellingson said that question leads to the more difficult question of what is the take-up percentage. For example, single parents who are providing for two children and themselves on $20,000 a year would probably not have extra money to spend at the end of the month. The take-up percentage would have to be 75% or 80%. Sen. Ellingson said that he did not mean to suggest that the Working Group was trying to straight jacket the Subcommittee into a final definition of "eligibility requirements". The eligibility requirements were simply ideas so that it could get a price tag.

Sen. Johnson asked about the response from the representatives of the insurance groups. Sen. Ellingson said that they were on board in terms of the process of getting the price tags for the options. However, none of them or the Working Group committed to saying that a tax credit is needed that is directed toward certain people, at a certain percentage of poverty, or that it is going to be 75% of the cost of insurance. Those are still very open questions. Sen. Johnson said that the basic problem is having people insured not what it does to the general fund and questioned how the Department or the Legislative Fiscal Division could even begin to estimate the numbers. He felt that it was not the Subcommittee's place to figure out what it is going to cost the general fund but rather decide whether it wants to insure people or not.

Sen. Nelson questioned the knowledge of the people who could use the deductibility or if they even knew that something was available to them. She felt that for years, they simply felt that they could not afford insurance. She felt that this issue should be addressed.

Rep. McKenney said that if the Subcommittee was going to make a difference, it must keep in mind that 86% of the uninsured people live in a household where one family member has a full time job. If it wanted to decrease the uninsured numbers, it had to help businesses and individuals and make insurance affordable so that they can buy it for their employees and themselves.

Rep. Thomas requested a glossary of terms being used, such as tax exemptions, refundable tax credits, deductions and from what, and attach a percentage to them, to give the Subcommittee a picture as to how it would affect $20,000-a-year household, for example.

Rep. Price requested that Rep. Thomas' request be tied to the 150%, 200% and 250% of the federal poverty levels.

Rep. Matthews asked if other states provided a deductibility and what percentage of uninsured people did they have. Mr. Higgins said that for businesses, the cost of providing health insurance to their employees is deductible. It is cost of doing business. His comment was made to establish the difference between how the Department reports that. For individuals, the 100%

deductibility is listed as an expenditure which is where the $21 million projected cost came from. For businesses, the deduction is still 100%, but it is not identified as specifically related to health care premiums.

Claudia Clifford, State Auditor's Office, said that the Subcommittee should not underestimate the importance of the participation that it has from the Chamber, the insurance industries, consumer groups, and the Governor's Office. It takes a bipartisan effort to review a serious proposal to address the uninsured. The Subcommittee is considering an approach that other states are reviewing--a tax credit. President Bush is also offering tax credits at the federal level, but the discussion is not nearly along the path as it is in Montana. She recommended that the Subcommittee keep working on it.

HEALTH CARE ADVISORY COUNCIL DISCUSSION

Nancy Ellery, Former Administrator, Health Policy Services Division, Department of Public Health and Human Services (DPHHS), provided a summary of the Health Care Advisory Council's presentation to the Joint Subcommittee on Health Care and Health Insurance. (EXHIBITS #2 and #3)

Rep. Schmidt asked if in Ms. Ellery's tenure, did the Health Care Advisory Council accomplish what it intended to do. Ms. Ellery said that the Advisory Council did accomplish some things while the Health Care Authority established a single-care plan within a regulated multi-payer plan. The 1995 Advisory Council accomplished what the Legislature directed it to do--to develop a report that outlined approximately 15 recommendations to deal with the issues of the uninsured, health care costs, and access in general. When the Advisory Council replaced the Health Care Authority, it was asked to establish a design for a health-information network that included information from all stakeholders and a consumer report card. The process was very open, but for multiple reasons, they were not approved by the Legislature.

Sen. Johnson asked if in view of the past Legislatures' failure to take the advice of the Advisory Council or the Health Care Authority, did Ms. Ellery believe that the responsibility should lie with DPHHS as part of its authority. Ms. Ellery said that it is part of the Department's responsibility, but it is also the responsibility of many other state agencies and the private sector. The Department's focus is more on the public-sector insurance programs that cover many people. Sen. Johnson did not find many state agencies that took advice from advisory councils and follow it. He asked how the establishment of another advisory council would have more control than what they did in the past. Ms. Ellery said that statutes limit what can be done through advisory councils. The Subcommittee may want to think differently about how advisory councils work. She felt that by just sticking the responsibility within the Department and having the councils just advise is not enough for a problem this enormous. Other states have used quasi-independent boards that have a lot of autonomy and authority which is an option.

Rep. McKenney asked who the participants on the advisory council would be and how often would it need to meet to be affective. Ms. Ellery said that an advisory council had to represent a cross section of all stakeholders within the health care system. The previous Advisory Councils had two Representatives and two Senator selected by Leadership, five members at large who were recommended by the Governor, and a representative of DPHHS. Ms. Ellery felt that membership should be broader and involve all key public- and private-sector entities. She added that at a minimum, there should be monthly meetings. She said that if the state spent $1 million

for a council over a biennium and when the state is spending approximately $8 million a day on health care, it is a very good investment if results are seen from it. She said that funding, staffing, and membership composition are critical for any council.

Rep. Schmidt asked how a quasi-independent board could be established. Ms. Ellery recommended that the Subcommittee review Washington State's board. She was unsure whether a quasi-independent board would work in Montana or whether Montana statues would even allow the establishment of such a board.

Tom Ebzery, Attorney representing St. Vincent, Holy Rosary, and St. James Hospitals, Billings, said that the reasons for the failure of the Health Care Advisory Council and the Health Care Authority was because they realized what a huge effort they had gotten into and how costly it was. Although the Advisory Council continued to try to find ways to address the issue, it ran out of funding and it fizzled out. He felt it important to have continued oversight and that it should be addressed by the establishment of a permanent interim health care committee consisting of representatives from the Senate Public Health and House Human Services Committees, along with public participation. The problem with advisory councils is that they make recommendations, they go home, and are never heard from again. If there is an interim committee that makes recommendations, its members can help implement the recommendations through the Legislature. There is a wide variety of public assistance to help the interim committee, and it should be an expenditure of the Legislature and staffed by the Legislative Services Division. He felt it the best way to go for continuity and learning curve purposes.

Don Allen, MT Association of Insurance and Financial Advisors, said that the suggestion of a permanent legislative interim committee on health care and health insurance was the right suggestion. He felt that it would be much more effective in staying on top of the issue by reviewing it on a constant basis.

Following a brief discussion, Rep. Schmidt agreed with the suggestion of a permanent legislative interim committee while other members questioned whether there could be the combination or blending of a legislative interim committee and an advisory council, such as the Environmental Quality Council.

STATE PLANNING GRANT PRESENTATION

Ms. Ellery gave a power point presentation on the state planning grant to secure financial resources needed to conduct an in-depth analysis of the uninsured population in Montana and to determine the most effective options for providing the uninsured access to affordable health insurance coverage. (EXHIBIT #4)

Sen. Johnson asked about the funding to cover the incurred costs of the statewide meetings to discuss the coverage plan and the State Planning Grant website. Ms. Ellery said that most of the activities will be funded by the grant after the grant is received, with the exception of the Governor's Summit. Sen. Johnson asked about the size and length of the grant. Ms. Ellery said the application calls for approximately $788,000 in funding and the state must spend the money within a year. The Department is ready to go forward just as soon as the grant award is received, and the grant runs from July 1, 2002, through June 30, 2003.

Sen. O' Neil asked if the 18.5% uninsured population included Indians currently in Indian Health Services and low-income people on Medicaid. Ms. Ellery said that the grant does not include people who have insurance through Medicaid, CHIP, or any public-insurance programs. Until one year ago, the Census Bureau counted Native Americans as insured because of their access to Indian Health Services. According to the current population survey, IHS is no longer counted as insurance resulting in the Native American population not being counted in the 18.5%. The 18.5% has been adjusted to reflect the new question being asked on the current population survey.

Sen. Ellingson asked if Ms. Ellery was confident that the grant application would be approved. Ms. Ellery felt confident that a good grant had been put together, but she was unsure how it would compare to other states. She said that the problem that may hurt Montana's chance of receiving the grant is its high rate of uninsureds because the federal government prefers to give the grants to states with low rates of uninsured. Sen. Ellingson asked assuming Montana received the grant, would Ms. Ellery coordinate with the work of the Subcommittee. Ms. Ellery said that she would not be administering the grant if it is received. However, there will be close collaboration between the Subcommittee and other entities that are working on the issue. She hoped that members of the Subcommittee would become members of the State Planning Group Steering Committee. Sen. Ellingson commented that he hoped that in the administration of the grant, that all efforts be coordinated so that a 2-year period of time will not be lost.

Sen. Johnson asked **Maggie Bullock, Administrator, Health Policy and Services Division, DPHHS**, how much money the Department will spend in getting the grant prepared. Ms. Bullock said that to implement the grant July 1, 2002, the Department will not have spent a great deal of its time and resources. Ms. Ellery spent much more time on this effort at a very minimal cost.

MULTI-STATE PRESCRIPTION DRUG PURCHASING POOLS

Jeaneen Campbell, Budget Analyst, Office of Budget and Program Planning (OBPP), provided three summaries of presentations she heard at a conference she attended that was held to address federal and state health policy issues, one being the rising cost of prescription drug care. She proved a copy and overview of Controlling Costs and Improving Access: A Focus on Pharmaceuticals presented by Gail Margolis, Deputy Director, Medical Care Services, California Department of Health Services; Controlling Costs and Improving Access: A Focus on Pharmaceuticals presented by George Kitchens, Bureau Chief, Florida Medicaid Pharmacy Services; and Health Insurance Coverage in an Era of Flexibility and Innovation presented by Tom Susman, Director, West Virginia's Public Employees Insurance Agency. (EXHIBIT #5)

Mr. Higgins stated the following:

- In his conversations with Mr. Susman, West Virginia chose ExpressScripts to be the pharmacy benefit manager (PBM) for four states that are pooling their public employees and dependents for prescription drug bulk purchasing.
- West Virginia figures to save approximately $7 million a year, however, rebates are the issue.
- PBMs get paid in terms of how the rebates work in their negotiations with drug companies.
- When West Virginia was working with other states, the idea was to move the market share out of the bottom line of the PBMs in exchange for providing an opportunity for the PBMs to have a huge pool.

- West Virginia's old rebate was approximately $1.50 per brand-name prescription. Under the ExpressScript contract, that amount is $6.10.
- Along with the four states, two other states are currently meeting with them to see if they could join. There is a managed care company that is also interested.
- ExpressScript requires a 3-year commitment from each of the parties.
- While, West Virginia and other states had concerns about the long-term commitment, they did manage to get language written into the contract that allowed them to back out after the first year.
- It is deceiving simple as to whether Montana wants to join.
- Mr. Susman recommended looking at Montana's current statutes and seek permission to join an multi-state purchasing pool.
- If permission is not needed, send a letter to West Virginia and the purchasing pool.
- Since West Virginia's contract requires that ExpressScripts take on additional parties, it is quite possible for Montana to make inquiries.
- The first go around with the multi-state purchasing pool is simply for West Virginia's public employees. The plan is to scale this into other opportunities to widen the pool if the first plan works.

Jim Smith, MT Pharmacy Association, said that at the Subcommittee's September meeting, he talked about the number of small- and medium-sized community retail pharmacies in Montana which are scattered across the state. The standard reimbursement mechanism that they operate under is a combination of the cost of the product and the cost of dispensing the product. Most of the reimbursement formulas take the average wholesale price (AWP) minus a percentage of the AWP plus a dispensing fee. Medicaid is also important to community pharmacies, and they have a reimbursement formula of the AWP minus 10% plus a dispensing fee of $4.20 because Medicaid puts a very high premium on access to pharmacies.

On January 1, 2002, the state employee plan switched from ExpressScripts to Eckherd Health Services Services. As part of the switch, the reimbursement formula was changed resulting in a net reduction in reimbursement to smaller pharmacies. Also, due to budget constraints, Medicaid announced a 2.6% across the board reduction in reimbursement through an emergency administrative rule. On April 1, 2002, there was a change in the methodology in which Medicaid recipients have a financial responsibility. The state is moving from a co-pay mechanism to a co-insurance mechanism. Prior to April 1, the co-payment was $1.00 on a generic prescription and $2.00 on a brand-name prescription. Currently, it is either $1.00 or 5% of the total whichever is greater. The concern is that the pharmacies have people who are on extensive and psychotic drugs and they may not have the ability to make the co-payment. If there is a 5% assessment on the cost of those prescriptions, it will be a lot of money. As the state moves into co-insurance, it will be extremely difficult for pharmacies to eat the co-payment.

Mr. Smith added that another proposed emergency rule, effective July 1, 2002, is a change in the reimbursement formula. As proposed, the reimbursement will go from the average wholesale price minus 10% to the average wholesale price minus 15% plus a dispensing fee change. The bottom line is that it is a net reduction in reimbursements to pharmacists. The Association is also concerned about the move to multi-state purchasing pools because the state contracts out the administration of the program to an out-of-state corporation. PBMs have been ratcheting down pharmacy reimbursements for the past eight years because that is the way they are

saving their clients money. They are taking it out of the pharmacists bottom line. The fundamental policy questions are does the Legislature want the small-pharmacy component of the health care infrastructure in place in Montana and are there other things that can be done other than ratcheting down the reimbursement rates to pharmacies. Mr. Smith said that the Association will continue to work with the DPHHS and the Committee on cost containment issues.
Sen. O'Neil asked about the preapproval of prescription drugs. Mr. Smith said that a new drug on the market or a drug for a rare disease has to be prior authorized, and many of the drugs are prior authorized because they have been used over a long period of time. The Association believes that there is a cost savings and there should a greater emphasis on generic substitutions and the purchasing of over-the-counter drugs in lieu of brand name or generic drugs. Sen. O'Neil asked if it made sense to have a higher co-pay required for brand name drugs than generic drugs. Ms. Smith said that Montana currently has that ($1.00 for generic and $2.00 for brand name). It was important to communicate that cost sharing be part of the equation. The switch to co-insurance caught the Association members off guard because the financial responsibility is much greater for certain people who need certain drugs which are reaching the area of being unaffordable.

Rep. Price asked how the AWP could be reduced and would the Association object to participating in a multi-state purchasing pool. Mr. Smith said that anything that could be done to lower the acquisition price would be accepted by the Association. The concern lies with the contract associated with the PBM program.

TOBACCO SETTLEMENT TRUST FUND

Roger Lloyd, Senior Fiscal Analyst, Legislative Fiscal Division, provided a status of the tobacco settlement funds. (EXHIBIT #6)

Greg Petesch, Director, Legal Division, Legislative Services Division, stated the following:

- Section 17-6-602, MCA, enacted by the 2001 Legislature, defines "benefit services" or "coverage of health care needs" which is defined as the provision of health care to persons of the state through any program of benefits, services, or coverage, including income tax incentives.
- The definition for "tobacco disease prevention", which is the other permissible use, is programs administered by the state for the purposes of informing individuals of the health risks of tobacco use and exposure, assisting persons in avoidance of tobacco products use, and assisting individuals in the cessation of tobacco use.
- These are the constitutional restrictions in the use of nine-tenths of the interest income or, with a two-thirds vote, an appropriation of the principal of the tobacco trust fund.
- The flow of the remaining settlement proceeds into the general fund is the subject of a proposed initiative that would earmark an additional 49% of the settlement proceeds and split it between the two defined uses.
- If successful, the general fund will receive only 11% of the settlement proceeds.

Sen. Nelson asked if Attorney General McGrath was suing the tobacco companies for late or nonpayment of the settlement funds. Mr. Petesch said that several pieces of litigation exist that could affect the trust fund, one being for certain companies that have late payments. If the payments are late, the state would get the payment plus interest on the payment. The interest on

the payment would be part of the settlement proceeds and would be allocated, under current law, 40% to the trust fund. There is also litigation existing where an individual is suing Montana for a portion of the trust proceeds claiming that the settlement precludes the individual from suing the tobacco companies privately. The state is disputing any liability in that case claiming that the settlement does not preclude individuals from bringing forth their own claims.

Sen. Ellingson asked if the $9 billion paid to the states after 2018 would be paid each year and is it spread among the settlings states. Mr. Lloyd said that the $9 billion is an annual payment which is shared among 52 settling parties. Montana's percentage of the $9 billion is .41% adjusted for inflation and tobacco use. Sen. Ellingson asked if assuming that the tobacco companies are around and do not go bankrupt, could Montana can count on these fund into perpetuity. Mr. Lloyd said yes.

"BASIC BENEFIT" HEALTH PLANS AND MANDATED BENEFITS

Mr. Higgins provided a summary of "Basic" Health Insurance: An Option for Consideration. (EXHIBIT #7) Mr. Higgins said that the Subcommittee needed to consider tying some type of a plan to the proposed tax credit in order to control costs and to get a better handle on take-up rates.

Rep. Lawson asked what a basic health insurance policy would cost as a percentage compared to what a full-blown policy would have cost in 1991. Mr. Higgins was unsure but he would ask the insurance industry. Rep. Lawson said that he liked the idea of a tax credit that is tied to a medical savings plan as another option to consider and as another safety net to fall back on.

Sen. Ellingson asked if there was currently a market for a basic health insurance plan. Mr. Higgins said that according to his research, the idea behind a limited benefit plan was initially to say that a limited benefit plan operates in the traditional way that insurance should operate in that it will protect a person from catastrophic loss. He speculates that there would be the recognition that as part of the purchase of a basic plan that protects people from catastrophic loss that they would be employing alternative methods of paying for preventative care. He felt that the insurance industry would say that there is somewhat of a market for a basic plan, but it was difficult to make a general statement about the size of the market or the interest.

Rep. Matthews asked about the Blue Care program which is a limited plan offered by Blue Cross Blue Shield of Montana (BCBSMT) and how the plan was similar to a basic health insurance plan. **Chuck Butler, BCBSMT**, provided a brochure explaining the Blue Care Plan. (EXHIBIT #8) Mr. Butler said that participating hospital CEOs offered a 50% discount for the services provided under Blue Care because working poor individuals were receiving care and because they would rather receive 50 cents on the dollar as opposed to nothing. Participating doctors across the state are also taking a 50% discount in charges under the program. He said that premiums for Blue Care are based upon the 50% discounts from the hospitals and doctors. Mr. Butler said that full-benefit package premium rate ranges are three to four times more than the Blue Care Plan for individuals who are 30 years old--$120 to $250 a month depending upon how good of a benefit plan individuals want. He added that currently the fastest selling benefit plans offered by BCBSMT are the $2,500 deductibles with a 50-50 co-pay for individuals . Rep. Matthews asked if Mr. Butler felt that employers would use a basic benefit package if a tax credit was involved. Mr. Butler said that BCBSMT is optimistic. It is going to keep working at it and it supports the implementation of a tax credit. BCBSMT and Montana's Congressional

delegation is pushing for a tax credit at the federal level. However, it has mixed feeling as to whether it should be tied to a basic benefit plan or let the market place do as it pleases. He said that the people who the Subcommittee is talking about serving, individuals between 150% and 200% of poverty, are already struggling to buy health insurance that is basic today. BCBSMT will be discussing with its provider partners about taking the Blue Care Plan to a new level. Mr. Butler will provide the Subcommittee with an update at its June meeting.

Sen. O'Neil asked how the $2,500 deductible plan under BCBSMT compared with the Blue Care Plan. Mr. Butler said for example, an individual with a $2,250 deductible, the rate is $131 compared to $58 under the Blue Care Plan or $141 for an individual 25 to 29 years of age with a $2,250 deductible. On the hospital side, BCBSMT is paying bill charges and there is a 15% reduction on the doctor reimbursements. This shows the significance of the substantial reductions by hospitals and doctors for the Blue Care Plan.

Sen. Nelson commented that people were more concerned about catastrophic coverage and that a basic plan was needed more in the rural and agricultural communities because they have assets that they need to protect.

Rep. Lawson asked if BCBSMT sold catastrophic insurance along with the Blue Care Plan. Mr. Butler said no that the Blue Care Plan is a plan that people can afford and that is all they can afford. As stated, the Blue Care Plan includes a $10,000 annual maximum benefit. However, if a person is hospitalized, there is actually a $20,000 benefit because the hospital would accept the 50% reduction. Hospital partners in the Blue Care Plan will say that people who do not have the Blue Care Plan will be treated, cared for, operated on, and run up whatever the bill may be but that the hospitals will end up with a bad debt or charity care at a cost shift. According to BCBSMT statistics, 60 out of 1,000 people will end up in the hospital. The odds are that they will have one hospitalization coverage, if that, and hospitals would rather receive one-half of something rather than taking nothing.

Sen. Ellingson asked if Mr. Butler believed that there was a market for a basic health care plan. Mr. Butler said that he believed that there was a market for it. Assuming that the Subcommittee recommends a tax credit, the recommendation should that there be a basic plan available if there is a market. He encouraged the subcommittee to invite the providers to the table for the discussion because making the price of the premium affordable is going to require their support.

Sen. O'Neil asked if the Blue Care Plan had the exemption options provided by HB 693 from the 1991 Session, would it be cheaper to sell. Mr. Butler felt it would be cheaper but would provide the Subcommittee with a cost analysis at a later date. Sen. O'Neil also requested that Mr. Butler think about other legislation in Montana that is keeping the price of health insurance high.

Rep. Schmidt asked about the current status of the other states that have provided "bare-bones" policies. Mr. Higgins will provide the information, but said that what would be of most value is what the plans are and if changes were made to them. He said that Legislatures have reviewed the idea of creating or recreating this type of opportunity, and through NCSL, he could get a sense of where states are at and if their conditions and attitudes have changed.

PUBLIC COMMENT

Claudia Clifford, State Auditor's Office, said that there are many health plans on the market. that offer many types of varying high deductibles to very limited benefit plans that may cover only specified diseases. When the Insurance Commissioner's tax credit met, it discussed the fact that there is a limited amount of dollars that can be spent on a tax credit and that it should not be designed to encourage everyone to buy a Cadillac. The costs must be contained, and it is done by capping the tax credit. She recommended that the Subcommittee not tie the tax credit to a specific plan only or certain plans and to let the market work. She said that consumers are fussy and they have their own needs. She added that according to BCBSMT's estimate, the cost of all of Montana's mandated benefits in aggregate is $12.70 on the average price that they sell a plan for. The Subcommittee must keep in mind that the mandated benefits are not the key to the cost. Most of the cost is covered by the insurance product, and cost is key because that is why people do not buy coverage. The chunk of the cost is the benefit of the plan. She also believed that a basic plan is not the key to solving the uninsured problem.

Jane Ragsdale, Missoula, said that the conversion from nonprofit to for-profit health care entities is not as immediate as what the Subcommittee is considering. She knows how much anxiety develops when a nonprofit health care facility converts to for-profit which has happened since the late 1980s at increasing speed. She said that many of the reasons for changing to a for-profit status is pressure and competition, often from hospital chains that are buying up the smaller and medium-sized hospitals. Smaller communities wonder if quality care will still be offered if the less profitable parts of a hospital would be offered by a for-profit company whose main obligation is the its shareholders. There are also questions about whether charity or indigent care will be cut and whether costs would be lowered by having fewer doctors or nurses. Ms. Ragsdale requested that any conversion legislation offered during the 2003 Session include a stipulation that the Attorney General or Insurance Commissioner be allowed to ask for public comment and to questions of the transaction or to request an independent evaluation of the assets to be put into an independent foundation that will continue the nonprofit's original mission.

Bonnie Adee, Mental Health Ombudsman, said that for varieties of reasons, individuals in the lower-income categories have a higher than average incidence of serious health problems, both mental and physical. When they lose their eligibility in the public mental health system, they fall over the cliff. Most generally, they lose eligibility because of an increase in their incomes, but they do not lose their clinical need. The question is would they then be interested in purchasing a basic insurance plan to cover the gap. The first question they will ask is will the basic plan cover the families particular medical needs. Unfortunately for many, a basic plan will not because these individuals rely on a rich array of benefits offered by the public system, including almost 100% coverage of pharmaceuticals. The choice then to pay a premium to get a benefit that does not meet their health needs is not an attractive or logical consideration. Ms. Adee added that this forces these individuals to keep their incomes within the eligibility range of the public health system in order to continue their family's health needs. She encouraged the Subcommittee to keep in mind those people who are in lower-income brackets and need access to the array of benefits in a public health system, including mental health.

Anita Bennett, MT Logging Association, said that the Association has both a state workers' compensation program and a group health insurance program. It has also been involved in health care reform. She said that the Association is a part of the 20% of the purchasing pool in the state. With the cost shifting, the Association helps hold up the 60% that is government subsidized and the 20% of the uninsured. When physicians talk about discounting services, they

shift the discounted costs. Affordability of group health insurance policies then becomes the question. Ms. Bennett requested that the Subcommittee review basic economic principles, such as supply and demand, what where the impacts of the changes in health care over the last 10 years, or was consumer economic supply and demand impeded which added to the costs. She said that insurance was supposed to be for taking care of a loss, but she questioned whether it needed a different format or arena. Ms Bennett said that she is directed by the Association's membership to question whether it will or will not have group health insurance in the next few years. She must find an affordable product for its membership.

Riley Johnson, National Federation of Independent Business (NFIB), said that the average member of the NFIB has two to three employees, and a vast majority of them are within the 18%. He said that for many years he has supported the concept of basic health care policy, but he felt that the state should not be targeting the 18% because he did not believe that they would pay for it, not even with a tax credit. Cost is the driver of the issue and small businesses should be targeted to encourage them to buy some type of insurance that individuals will not buy themselves. He felt that the state was treading water to get individuals to buy health insurance. However, if insurance is offered by the employer, they will take it. He suggested that the Subcommittee review the idea of a Montana Blue Care Plan, much like the BCBSMT Blue Care Plan, that would be $25,000 maximum limit, a 75% sharing of cost with hospitals and doctors, and so many visits per year. He was confident that the majority of NFIB's membership who do not currently carry insurance would consider it. Catastrophic insurance that employees could buy on their own could be offered above that. If it is the Subcommittee's intention to get people physically covered by insurance, it should consider his suggestion.

Don Allen, MT Association of Insurance and Financial Advisors, is currently surveying its members regarding some of the issues that the Subcommittee is considering. There has been overwhelming support for a tax credit, but they feel that it should be available to all who purchase health insurance and that it should be a free-market type of credit rather than one that is government sponsored. Mr. Allen will provide more information to the Subcommittee at a later date. Mr. Allen said that he was also in favor of not having health care advisory councils. He felt that the Legislature should make those types of decisions.

SUBCOMMITTEE DISCUSSION AND INSTRUCTIONS TO STAFF

Prescription Drug Benefit Proposals

Shannon Marr, Pharmacy Program Officer, MT Medicaid, said that she would be willing to attend the Subcommittee's June meeting to present more information on what the program is currently doing and what other states are doing. She said that Medicaid is doing a number of things in order to contain costs in its pharmacy program. For fiscal year 2002, its estimated budget is $78 million for pharmacy expenditures, it has seen a 17% increase in between years, and it expects that percentage to increase. She said that in order to contain costs, the Department is doing the following:

- It requires a mandatory generic-drug substitution program, unless there is a clinically documented reason as to why a person needs a brand-name drug.
- It requires an extensive preauthorization program.
- It is operating under an overall environment of containing costs throughout the rest of this fiscal year and the first one-half of the biennium.
- It made changes to the 2.6% reduction in reimbursement rates for all providers.

- It is currently making changes, through the rulemaking process, to change the reimbursement rates to pharmacies (AWP less 15%).
- On April 1, 2002, the change to how cost sharing works for Medicaid recipients took effect. This was not an emergency rule.
- Medicaid recipients are now expected to pay 5% of the Medicaid amount or $1.00 which ever is greater.
    - Ninety percent of all Medicaid drug claims will fall under the new system between $1.00 and $5.00 for co-insurance requirement.
    - There is a $500 cap per fiscal year for Medicaid recipients for all services. It was previously $200.

Referring to a letter that he received from the National Association of Chain Drug Stores, Sen. Johnson asked if the Department was currently in contact with the National Association. Ms. Marr said that in an effort to involve as many people as possible in the process of rulemaking in regard to the changes to reimbursement, The Department has notified Mr. Smith and members of the MT Association and has also been in contact with Lis Merten who is the advocate for all retail pharmacies nationwide. They are concerned about what Montana as well as what other states are doing in regard to the changes to reimbursement to pharmacy providers. The issue brought up is that it would like to propose that there are other alternative cost containment measures that the Department could undertake. The Department is pursuing those avenues, but currently, the more imminent budget cuts must be done right away. A representative of the nationwide retail pharmacy group did not attend any of the rulemaking hearings related to the change to cost sharing nor did they submit written documentation with regard to the changes.

Sen. Johnson said that he had contacted the representative of the National Association and discussed the alternatives being referred to. The representative requested that the Subcommittee send a letter to the Department encouraging it to work with her group to identify all of the alternative cost containment measures. **Jeff Buska, Medicaid Services Bureau Chief DPHHS**, said that the Department would welcome all help to try to control pharmacy benefits under the Medicaid Program. It is also researching what other states are doing to contain pharmacy costs and reviewing a case management model for recipients who have a high number of prescriptions. Mr. Buska added that he would like to work with Sen. Johnson and representatives of the National Association of Chain Pharmacies. However, it may involve finding additional contract funds for the Department. Sen. Johnson felt it unnecessary for him to work with anyone on his own. He would much rather accommodate the National Association. The letter indicates a number of companies who the National Association represents, one being the largest company in the world--Wal-Mart. If the Department is looking for funding, it may be a very good source to receive that funding.

Sen. Johnson **moved** that the Subcommittee write a letter to DPHHS encouraging it to work with the National Association of Chain Drug Stores to identify alternative cost containment measures related to reimbursement rates to pharmacy providers.

Sen. Roush was concerned about Wal-Mart's offer knowing that it could compete with anyone and offer a better package. He said that Montana's rural community drug stores are closing because of the large chain stores. He felt that if Wal-Mart helped, it would shut down more private pharmacies in the state. Sen. Johnson agreed, but said that large chain store are in Montana and they will continue to come in greater sizes all of the time. The Subcommittee is

discussing how the large chain stores dispense pharmaceuticals and at what price. He felt that this was an opportunity to see if the large chain stores could do anything. The National Association was asking for help. It was not saying whether large chains were going to run small businesses out of business.

Mr. Smith said that there are tensions within the communities between chain and independent pharmacies. However, not even Wal-Mart could purchase prescription drugs at discounts that are routinely available to help maintenance organizations, mail-service pharmacies, and institutional purchasers. When it comes to acquisition costs and if Wal-Mart has problems, then everyone has problems. Mr. Smith said that the MT Association would like to work with the National Association and the Department on the issue.

Sen. Johnson's motion passed unanimously.

Rep. Lawson requested that the motion include the MT Pharmacy Association. Mr. Smith felt that another motion was unnecessary because he knew that the doors were open for the MT Pharmacy Association's participation in the process. Sen. Johnson said that his motion was meant to include all organizations that were willing to participate in the process.

Rep. Lawson requested copies of the letter that was sent to Sen. Johnson from the National Association of Chain Drug Stores.

The Subcommittee requested further research on what other states were doing in the area of prescription drug benefits. Staff will provide information on the West Virginia-led coalition--a copy of the contract, the RFP, and the benefits associated with the purchasing pool, keeping in mind that the plan is specifically for public employees.

Sen. Ellingson requested additional information on Maine's Multi-State Purchasing Pool Plan. Mr. Higgins said that the Tri-State Coalition with Vermont, New Hampshire, and Maine is also starting with public employees because of the easily recognizable pool. However, they may be closer to expanding that population to seniors without prescription drug benefits. Mr. Higgins will also provide more information on the resolutions passed by the States of Idaho and Washington requesting their sister states to begin the process of reviewing a multi-state purchasing pool. They have asked that Montana adopt a similar resolution.

Tax Credit Proposals

The Subcommittee requested that staff begin working with the Legislative Fiscal Division and the Department of Revenue to establish price tags to the various option that the Tax Credit Working Group was looking at in the tax credit area with a special emphasis on employers who will be buying insurance, but yet, not neglecting individuals.

Funding Options

The Subcommittee agreed to discuss all funding options that may be available, even though it will be a policy debate in the 2003 Legislature.

Health Care Inventory

Mr. Higgins said that in talking with the stakeholders who have proposed the idea of a health care inventory, he recommended that the Subcommittee review whether it wants to make a recommendation on the issue. If it did, he would work with the stakeholders to determine the framework of the inventory. He said part of the discussion would be the perceived benefits of creating the inventory as well as the costs associated with establishing a database and how it would be used. To a certain extent, the Department has databases that reflect licensing and a current disease registry that could be incorporated into an inventory. In addition, a recommendation of the Legislative Audit Division was that the Department comply with the requirement that it create a health care database. The Department, in its response, agreed that if statutes requires this database, it should be doing it. However, the Department requested funding over the last three bienniums to accomplish the task, but it was not provided.

Other Issues

The Subcommittee previously discussed the recreation of a Health Care Advisory Council much like that of the Environmental Quality Council (EQC), and the Subcommittee questioned whether advisory councils did any good.

Mr. Ebzery felt that there should be a legislative interim committee proposed instead of an advisory council. He said that the problem with non-legislative members on a proposed committee is that there may not be enough places for all stakeholders at the table if a council was set up like the EQC. He felt that in this case, it would be better served to establish an interim committee and it should be funded by the Legislature.

Mr. Higgins said that if the Subcommittee wants an interim committee that deals solely with the issue of health care policy, his recommendation would be that staff visit with the staff of the Legislative Fiscal Division, the Children, Families, Public Health and Human Services Committee, and other office directors and legal counsel because there will be a fiscal impact and it will require significant changes in how Senate Bill Nos.10 and 11 are structured. Staff will prepare an outline of what the proposed interim committee may look like and the changes that the Subcommittee will have to consider in relationship to the rest of the interim committees. The Subcommittee will also continue the formal review of health care issues on its agenda.

Rep. Schmidt **moved** that the Subcommittee support the continued study of the creation of a standing interim committee to review and monitor health care policy rather than the reestablishment of a Health Care Advisory Council. Motion passed unanimously.

Sen. Nelson said that in holding hearings across the state with the Education and Local Government Interim Committee, the biggest concern is the cost of insurance. It is an overwhelming burden to the school districts and to the teachers who are picking up a larger share of the premiums themselves. She requested that the Subcommittee consider the school districts and teachers while considering other insurance issues.

Other agenda items will include a discussion of the policy and fiscal implications of going to 200% of poverty for the CHIP program and a report on the health care costs in states that require certificates of need versus those states that do not require certificates of need.

The Subcommittee agreed to move its next meeting to June 13, 2002, and tentatively approved July 18, 2002, for its July meeting.

Staff will also begin working on the Subcommittee's final report.

Sen. Ellingson suggested that the Tax Credit Working Group review the requested preliminary figures via telephone conference call before the Subcommittee's June meeting.

There being no further business, the meeting adjourned at 4:30 p.m.

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